

# Inspiring Doctors. Episode 5: Jason Leitch

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## Martin

Welcome to Inspiring Doctors, a podcast series brought to you by the British Medical Association. I'm Martin McKee, a professor of public health and the president of the BMA.

In this series, I'm joined by people who I see as role models. They've successfully taken their medical knowledge to a wider audience in creative ways. So, what inspired their work? What lessons have they learned? And what advice do they have for young doctors who may want to follow in their footsteps?

There is something magical about the confluence of medicine and communication. My interviewees are only some of the role models who do this work. But they are all people who have inspired me. I hope that our conversations will in turn inspire you.

My guest today is Jason Leitch. Unlike most of my other guests, Jason isn't a medical doctor. He's a dentist by training, and he's now the national clinical director in Scotland. His public briefings during the COVID-19 pandemic have attracted widespread praise. After he qualified from Glasgow, he completed a master's in public health at Harvard and became a specialist in oral surgery. Jason then joined the Scottish Government in 2007 and progressed through a variety of roles to reach his present post.

He's described as someone who can translate complex scientific information to the public, and he has been willing to answer their questions on television shows. He was awarded a CBE in the 2019 birthday honours list. Welcome, Jason.

## Jason

Thanks, Martin. Thanks for having me.

## Martin

So, I tell my students that they should read political biographies. Typically, health issues at most have a walk-on role. Now, this isn't the case in Anthony Seldon's new biography of Boris Johnson. COVID gets an entire chapter, and it also features prominently in another chapter in that book entitled 'Cummings'. I might add that Chris Whitty and Patrick Vallance are among the very few that come out of this book rather well.

There is a biography of Nicola Sturgeon, but it was published in 2015, so I guess we'll have to wait for a new edition to gain similar insights about what happened in the pandemic. And of course, I know that you're still in post, so you are limited in what you can say, but I wonder if we can go back to the beginning of the pandemic.

When did you realise that this was going to be something really big? And what was it that made you realise this?

## Jason

Yeah, I'm not sure I can pinpoint an exact timeline. Like you and like everybody else, we were working it out in real time, which actually speaks to later on when we talk about how we try and communicate that. That's, of course, one of the challenges. This was science in real time.

Right at the beginning, of course, there were early signs from the WHO that there was a red flag. There were four strange pneumonias in Wuhan, China, that now, of course, with hindsight you can say, 'Oh, yes, I remember them.'

At the time, are you really paying as much attention to that? The WHO, remember, raise red flags like this 30 times a year on average. This one became very real very quickly.

And I remember a room in which the first minister, the deputy first minister, the CMO, me, couple of other advisors, we were in our small space, and she was distributing tasks and she looked at me. We'd known each other a long time, remember, she was the health secretary, she was my first health secretary in 2007 when I moved to part-time government.

And she said, 'I know what I'm going to have to do with you, but I just can't face it.' And I said, 'What are you talking about?' And she said, 'I'm going to have to put you on TV.' Because she knew that it was getting big enough that she couldn't do all of the communication by herself.

She couldn't lead it politically and lead it clinically. She needed clinicians beside her. And from that day – I think to her great credit, others may disagree – she never did a press conference by herself, not once, for two and a half years.

### **Martin**

During the pandemic, as you've said, you made an awful lot of public appearances with the first minister and with other politicians. And you just told us that this was something that she realised that you would have some hesitation about doing. And I'm trying to work out what was going through your head at the time, when you realised that you had to do this. Because some of the people who are listening to this may well find themselves in a similar position in some future crisis.

### **Jason**

Yeah, I think the only thing worse than being the national clinical director of a nation, and being involved in a global pandemic that we hope is a once-in-a-century event, is not being involved during that period. So, I wanted to contribute. Now I have a very limited skill set, frankly. You and I know each other a little, Martin, and I have a very limited skill set.

### **Martin**

I don't think that's true.

### **Jason**

One of the things I have limited skill and ability to do is rely on others' expertise and perhaps summarise that into sentences that people on *BBC Breakfast* or on *Good Morning Scotland* can understand. And that's what I tried to do. It became my role both at press conferences and in the media. And crucially, also, invisibly with stakeholders. So, the faith and belief leaders of Scotland, the business owners of Scotland, the people who run elite sport across the UK.

I became the kind of translator of the real public health experts who are doing the analysis and the observatories around the world. I had to then try and make that into language that the average mum in the street with her kids could understand why she was being effectively told to stay in her home, or why the advice was to close the mosques or close the synagogues or close the churches.

So, I felt as though I was contributing. And you don't have a moment. I mean, it's not like a job application. You're not sitting an interview on a Tuesday and the first minister says you've got the job. You basically are just in it. When you look back, you can't really see when it began and when it finished. You just went to work every day and you did the thing that was in front of you.

You could argue, I suppose – it's a little pompous – that some of my work up to this point had led to that. So, I've got limited public health education. I've got some comms experience because I was on TV and radio. I've been in the politics of a country for 15 years, and I'm a clinician. So, there were some things leading to that point I think, when we needed somebody to speak to the public. Perhaps I was standing in the right place.

### **Martin**

Well, I have to say, I'm struck by your modesty. I think most people would think that an MPH from Harvard is a more than limited public health experience. But I also do some media, and often I find when one has done an interview, you think to yourself, well, I wish I had said that different, or I wish I hadn't said that, or there was something I forgot to say.

I mean, I'm not looking for particular examples. But sometimes, I find that one really questions oneself and there's a sense of regret and so on. But you have to move on. How do you find that, if that ever has happened to you?

### **Jason**

It happens to me almost daily, Martin. I've done a couple of things, one of which might seem weird. I watch myself back. Now, I have an ego, of course. But I promise on my life, I'm not watching myself back because of my ego.

I'm watching myself back because I was doing it so much that I was trying to get better at it, and I was trying to avoid hesitation. I was trying to avoid repetition. I'm married to an English teacher, so I was also trying to get the grammar correct, which wasn't always possible. But I was also analysing and trying to make sure that the key messages were getting across to the audience we were doing. So, I did football phone-in shows for half a million people. I did the *Chart Show* in Scotland.

I mean, if you'd told me three years ago, you'll be on Scotland's *Chart Show* talking about public health advice, I'd have thought you were crazy. And I also did Radio 4 and let's call it posher media, where the audiences are different, and you adjust the message accordingly. So, I'd watch myself back.

And the second thing I did, is I tried to adjust the messaging according to the crowd, and I sometimes got that wrong. The most likely error for me is over-speaking, not under-speaking. So, I would sometimes get a little ahead of myself. It depends on the interviewers. So, when you're on Radio 4 – you'll have done it, Martin – when you're on Radio 4 you kind of are on your best behaviour. You're unlikely to over-speak on Radio 4, because you know that every word is being very closely analysed.

When you're on *Lorraine*, she puts you so much at your ease, you could just talk because you think you're in your living room. My danger was always *Lorraine* not Evan Davis on Radio 4. So, if you're feeling calm and reflective, you end up over-speaking a bit.

The classic example in Scotland was when I cancelled Christmas in October, which was a little bit early, and we hadn't fully decided to cancel Christmas. And I said that we should prepare for a digital Christmas. And I became the Grinch on every front-page tabloid for the next couple of days. So over-speaking rather than under-speaking is a risk for me.

### **Martin**

Now, you've said, and I paraphrase, 'If you don't have impostor syndrome in my seat, then you have misunderstood.' Do you still have imposter syndrome? Do you ever grow out of it? Do any of us ever grow out of it?

### **Jason**

I think if you grow out of it, you should leave. I honestly think that. That doesn't mean you should be crippled by a lack of confidence, or crippled by your inability to do the job. When I say I have imposter syndrome, I mean I don't think that I am the person to do these tasks necessarily. I will do my best. I will rehearse. I will make sure that I have the analysis available to me before I go on.

So, all of those things. But if you don't question how you're in the seat you're in, in these senior jobs, then I think probably it's time to move along and let somebody else have them.

You need to be careful, because there's a fine line between a kind of arrogance, confidence, and then not being able to do it at all. So, I am confident. Some in the Twittersphere would perhaps suggest there's an element of arrogance, I hope that's not true. And I certainly don't feel crippled by my inability to do it.

But there are fine lines in there. If you're going to do the thing – whether it's head and neck surgery, like my previous life, or communication with the public – you should treat it respectfully. You should prepare appropriately. You should have the data that you want to get over to the public available to you. You should be able to answer as many of the questions as you can. And you should have the humility to be able to say, 'You know what, I don't know the answer to that, but next time we're on, I will get the answer to that, because that's not available to me today.'

So, yes to imposter syndrome, but not to crippling imposter syndrome.

### **Martin**

And of course, one of the things we have seen during the pandemic is the way that people with really no knowledge of a topic are willing to speak with absolute confidence about it. And in particular, those who have been denying the importance of the virus and challenging the vaccine and so on.

### **Jason**

Yeah, it has been a big problem. The disinformation and misinformation challenge that we've faced in all countries of the world. Scotland and the UK have been no exception. Just this week that all reared its head again because we removed the final COVID extra masking rules in health and social care. And that's not even a binary argument, that's got every colour of argument you could possibly seek. Those who think we're trying to kill everybody with that rule, those who think we're two years too late with changing those rules, and everything in between.

All you can do, I think, is try in your small piece of the puzzle, try and follow the science as best you can. But science is neither absolute nor stationary. It is always relative and always changing.

So, you have to have the ability and the humility to be able to say, 'You know what? At the beginning, we thought this wasn't as important as it is now. Now we think this is the way to go. But tomorrow we may well have to change like that.' That happened quite often during the pandemic, where the science changed, sometimes during live interviews. You have to be able to do that.

And then you have to have a parallel track, which isn't for most of us, but that parallel track is managing the state actor disinformation, the real organised misinformation. So, for example, we had a letter that went to all schools from somewhere in the world telling them to send this letter about vaccination to every parent in their school. And it was a misinformation letter.

Now to tackle that, a head teacher, or you or me, we can't tackle that alone. We need the criminal authorities to tackle that. We have to manage that. But we have to let it happen in a parallel track while we, in the clinical communication world, try constantly to get the right information over as best we can.

And we have really good mechanisms for that across the UK now, some of which existed before but have got much better. The Science Media Centre, for example, is a great example of using recognised scientists, recognised clinicians into mainstream media to allow them to get those messages across.

### **Martin**

So, this point about how you move with the times as the science changes, it's really a difficult one, isn't it? There's the famous quote that we've all heard, 'Well when events change, I change my mind. What do you do?' And people argue about who said it first; was it the Nobel laureate Paul Samuelson, or was it John Maynard Keynes? But the point is that, as you have said, we do need to change our advice as the evidence changes.

But the difficulty with that, of course, is that when you do change your advice, there are always those who are willing to jump in – and very enthusiastically will jump in – and say, ‘Ah, you said that then. Now you’re saying this. Do you really know what you’re talking about?’ So how do we actually make it legitimate to change one’s mind whenever the evidence changes?

### **Jason**

I think we shouldn’t confuse mainstream listeners with fringe niche listeners. So, I now find it a little bit more challenging to walk down Scotland’s streets than I did before. The people who stop me for selfies or to shake my hand, and it happens – I mean, I can’t believe I’m even saying these words out loud – but it happens all the time.

They invariably want a picture for their mum or their granny, not for them. It’s usually the elderly, over-75-year-old women who wish to see me or speak to me. They have an absolute ability to know that science changes over time. They have a trust in that scientific communication. They have a trust in what we’re trying to tell them.

Now, on the edge of that there are mischief-makers, there are people who are going to say, ‘Well, two years ago there’s a video of you saying that masks weren’t so good in Scotland and now you’re saying that we’ve to wear a mask, and now you’re back to where you were before and we’re saying no masks again.’ Well, yeah, that is what we’re saying.

And that’s because, as we learned about aerosol spread, as we learned about young people versus older people, as we learned the people who got seriously ill from this disease was not the group we expected in March 2020, we’ve had to change our advice. Most human beings can do that. You can do that; your family can do that.

But some people have a particular agenda or a particular set of experiences. One of the huge challenges in public health communication is people think their experience is everybody’s experience.

So, ‘I had a very serious version of COVID, nearly killed me, nearly killed my mum. Therefore, we should take it much more seriously than you’re taking it.’

‘Hold on a minute. I had one day of a fever, went back to my work, felt nothing. So, therefore, it’s not a serious disease.’

Public health, of course, is taking that up to a population level and making choices for 70 million people, or five and a half million people, depending on where you live. That’s harder to communicate with the public. But most of the public understand.

### **Martin**

So do you think that we train our colleagues adequately in communication skills? In the public health course that I run, I actually have a separate section on communication that looks at cognitive biases, how you can tell people one thing and they interpret it in a completely different way. But I wonder if we’ve actually got all the learning.

There's a lot of research out there about 'prebunking' for example, about challenging, about the way in which you can correct something, and it actually reinforces the wrong belief in the first place. Do we do enough to ensure that everybody is up to speed with all of that?

### **Jason**

Well, the obvious answer there is no, Martin. But your work has helped us do that. And I hope this series will also help with some of that. But we don't treat, particularly public communication, with a high enough priority, as I think we should, both in public health learning, but also in general clinical learning. And in journalism and other places where this kind of stuff happens, I don't think we're traditionally as good at that as we should be. We don't tend to put ourselves forward as clinicians or public health experts.

I think the pandemic has changed that a little. We've now got to know, I mean, you can buy a mug with Chris Whitty's face on it. You can buy a cushion with my face on it if you so wish, although they may be sold out.

So there is something happening, but we need to take advantage of that. So, when the world wants to talk about vaping or wants to talk about minimum unit pricing of alcohol, then we collectively – not necessarily government people like me, but independent clinicians and scientists – should be in that equation and should be able to talk.

But there are skills you can learn to be able to do that. It's partly about speaking out loud in a straight line and being coherent. But it's also about how you might do that, the way you might do it, how you might use trusted voices in a different community from yours. Because I'm a white, middle – I was going to say old – middle-aged man, give me that.

And I'm not the person to speak to the Gypsy/Traveller community in Scotland. What I should do is speak to the Gypsy/Traveller trusted voices, and they will speak to the Gypsy/Traveller community. Substitute Jewish, substitute Polish, substitute African diaspora for Gypsy/Traveller.

And that's what we did. Vaccination was the obvious example, where we had some real challenges with some minority communities who didn't access mainstream media. We had to use their media. That's a good thing. We had to learn how to do that. And as a public health professional, I wasn't aware of how to do that but I had comms leads who could do it.

### **Martin**

That's really important.

Now we've already mentioned Harvard. You often talk about your time in the United States. And, as you know, I'm a great believer in trying to see ourselves as others see us. But we need to recognise that many people who go abroad do so as, in effect, tourists, seeing everything through their own lens.

Not everybody is a de Tocqueville. Alexis de Tocqueville wrote a very famous book, *Democracy in America*. Frenchmen going to post-revolutionary United States and having some incredibly

perceptive observations on how the society was working. So, he really got into it in a way that often one doesn't when one's inside the system. But not everybody is like him.

So, do you have any advice on how we can help people to see things that they're involved in differently, to step aside, step outside for a minute, to get that different perspective?

### **Jason**

I think that's principally about the cliché of walking in others' shoes, but I would suggest the shoes are maybe a little broader than we expect. I mean, people listening to this would expect us to say patients, families, customers, carers. Of course, if you're going to give advice to a care home, you should probably understand what the care home looks like, and you should probably understand what it is like to work in such an establishment. I've spent more time in care homes in the last year than I've spent in my whole career trying to do precisely that.

But there are also, perhaps more broadly, other subject areas and experts who can help us. Heaven forbid that journalism, newspaper editors, broadcast media editors could help us, and the good ones really can.

I think the public service broadcasters in the UK had a fantastic pandemic. Both the BBC and ITV, and Sky and Channel 4 as well. They were, in the main, they were about getting the right messaging across to the public. Now they were questioning and enquiring, of course, that's the job. But in the main, I thought they did well. So, spending time with the people who do that for a living helps you then become better at getting that messaging across.

And it also helps them spend time inside health and care. Fergus Walsh is the obvious example on the BBC, who probably did more for public understanding of what intensive care was like, what it was like to be a worker at the sharp end of COVID in primary care and in secondary care, than any other journalist in the country. I think that's really important, and I think clinicians should spend time with them as they should spend time with us.

Walking in the shoes of, let's call them broadly the customers, those we serve, is also crucial. So, hearing from the public. That's why I did a lot of phone-ins. Phone-ins are hard. I'm sure you've done them. They are not straightforward and the demographic of the phoner can get you in trouble quite quickly because you are often asked individual personal questions for their care, which you clearly can't answer. So, there's a skill set in there for your ability to do it. But it does help you feel for the population.

Politicians, in my experience, are much better at that than clinicians. Politicians, good politicians, have an instinct for public mood that I never understood, I could never do. Nicola Sturgeon was brilliant at it. She knew when the public would move in the direction we needed them to move in, because she had an instinct for public mood from 30 years in politics.

### **Martin**

Yeah, well, I have done a number of phone-ins too, mainly on Radio Ulster, and I have to say they're really quite challenging. I find them incredibly difficult because often you find that you're biting your tongue and there are things that you might like to say, but obviously you

can't. So, I'm just wondering, are there any particular tips that you have for people who find themselves in this situation?

I mean, maybe the best advice is don't do them. But I think there is an argument for going out there and engaging because there are often genuine questions. And maybe I should add of course, at Independent SAGE, we had questions from the public every week where we were trying to explain often complex concepts. So, there is an argument for doing it, but sometimes they can be very challenging.

### **Jason**

They are. I don't think it's where you should start as a clinical external communicator. But I think they're important and I think you should do them, once you have the skill set. It's partly an expertise skill set. So don't do an oral health phone-in if you don't know anything about oral health.

But once you're there, the trick usually is to generalise from the specific. So, when Mrs Jones comes on and asks you about her endometriosis and why the doctor hasn't seen her on time, you of course empathise and help Mrs Jones. But then you talk more broadly about what we're trying to do for waiting times, how you might challenge and be assertive in your community and get that, whatever. So, you take it from the specific example that you're given in the phone-in, and you try and generalise.

Now that's sometimes possible, sometimes not. I did 18 months of Scotland's football show on a Saturday afternoon, because there was no football of course, and we did Q&A every week, some of which was absolutely wonderful. And some of it was, frankly, weird.

I was asked one day if trapeze was a contact sport, because we had just stopped all contact sport. You were still allowed to do non-contact sport, so you were allowed to play tennis, but you weren't allowed to play football. So, I was asked by the Scottish trapeze society if trapeze was allowed.

And quick as a flash, I don't know where it came from. I said, 'Well if you do it well, it's a contact sport and therefore not allowed. But if you're rubbish at it and you don't touch the person who's trying to catch you then no, it's a non-contact sport and you'd be allowed.'

So, I'm not sure how many trapeze artists there are in Scotland, but there is a society who phoned into the football phone-in.

### **Martin**

Yeah. One of the things I'm finding in this podcast series is that there are lots of groups about whom I had no knowledge before, so that's another one to add to the list. I should at this point just clarify in case the General Medical Council are listening that I am of course fully aware that you should never give individual clinical advice to anybody on the radio if you haven't examined them. So, let's just get that one out of the way.

So, one of the things that I've got a particular interest in is the relationship between science and policy. Some of your counterparts have argued that they should be kept completely

separate; scientists simply advise. And others take the view that scientific advice doesn't exist in a vacuum, and it should take account of context.

And maybe we can link this back to one of your earlier answers about care homes. As a concrete example, my colleague John Edmunds, who is one of the country's leading modellers, said that SAGE suffered because it lacked information on the situation in care homes and in particular, how some staff were working across several care homes and therefore moving infections from one to the other.

So where do you stand on this science-policy interface? And I know that in your lectures and some of the talks I've listened to, you've used the word 'boundarylessness', and maybe you could help us with that particular term in relation to this debate.

### **Jason**

Yes, it's a made-up American word. It's to try and define the lack of artificial boundaries between these places.

There's one very important distinction, before I fully answer your question. And that important distinction is that in a parliamentary democracy, the decision makers are elected, not advisers. And I think that's absolutely crucial. Now, was it Winston Churchill who said, 'Democracy is the worst form of government except all the other ones we've tried.' So, there is an element of inadequacy about that, but that's what we've got.

So, I was absolutely clear that during these three years, the people making the final choices were the elected politicians in the country and across the UK. So, Nicola Sturgeon and John Swinney and the health secretaries were the ones making the choices in Scotland.

Now, when you're asked to give advice, it's not always a straightforward written briefing that says, yes you should introduce minimum unit pricing of 50p per unit of alcohol across Scotland, yes or no?

Often our advice was much more nuanced because when we gave public health advice, the chief economist who was in the room was saying, 'Yep, do what Jason says. But if you do what Jason says, here's what'll happen to unemployment, here's what will happen to the business community.' So, there's a conversation. The advice is not a single piece of paper that goes in splendid isolation to the decision makers.

So, I think you have to be able to have that science, policy and clinical expertise conversation in a room. But let's not forget that when you're done, the person making the choice is the person in the elected seat. And I'm very glad I wasn't Emmanuel Macron or Boris Johnson or Nicola Sturgeon because that seat was the hardest. No question. That seat was the hardest.

But to give the advice, you do the best you can in the moment you're in, to give the best advice you can, and then you genuflect and you leave, and you leave the decision makers to make those choices.

And we had armies of advisers, including you, including SAGE, Independent SAGE. We had a version in Scotland called the Scotland COVID Advisory Group, chaired by Andrew Morris. We had all kinds of public health professionals, but we also had economists, behavioural scientists. We had people who did social policy, so said, 'If you do this, this is what will happen to loneliness. If you do this, this is what will happen to education.'

So the conversation is much, much more complex than it seems, if it's just public health advice. Because public health advice for an infectious virus, you don't know what it's doing, is pretty straightforward – put everybody in their homes and wait for it to pass.

That has massive implications, of course, because you're going to do this to the health system, you're going to do this to education and you're going to do this to the economy. So, the conversation becomes much more complex. And that's where I think you just have to do your best telling the truth in every moment.

### **Martin**

And of course, right at the beginning of the pandemic, we wrote a paper led by Margaret Douglas and other colleagues in Scotland, which looked at all of the consequences of locking down. You know, accepting that restrictions were necessary to stop the virus being transmitted, but also that there was a need to take account of what would happen as a result of that.

But you describe, in a way, you're getting evidence from public health, from the economists and so on. But one of the things that politicians sometimes say is, 'Well, yes, it's all right to give us the public health advice, but we have to take into account other issues.'

Now, you've described the economic issues which were explicit there, but often those other issues are not made explicit. And again, reading political biographies, you know, it can be the visibility of a particular minister or the impression that they want to get to a particular section of the electorate, and these are never actually voiced.

So, I think – I don't want to put words into your mouth, but what you're saying is – all of the different things do need to be weighed up, but it's probably a good idea if they can be done so explicitly rather than having hidden agendas.

### **Jason**

Yeah, I agree. So, here's a surprise for you, perhaps. I was in a lot of rooms I didn't expect to be in during this period, both communicating and advising. And I never met a politician who wasn't trying to do their best, not once.

Now, I'm sure if you work hard enough, you can find one who isn't trying to do their best. But you can also find that in psychiatry, public health and oral surgery, frankly. But I never found a politician who wasn't trying to make this better.

Now, that didn't mean they were all on the same page and they didn't have different lists of priorities. And that they didn't reorder the priorities depending on who they were and what they were doing. And they all had different versions of the world and different personalities. But in my experience, the ones I dealt with were all trying to do the right thing.

What the right thing was, was of course quite hard to discover, because it wasn't a game show where there was a 'win' door and a 'lose' door. There were 16 doors, and they were all bad. So you had to choose the one that was the least bad, using your value set, your country's ability to do what it was meant to do, all of that. And that's different in a 70 million population and a five million population. It's different in a 250 million population in the US, it's different in China, and it's different according to what government structure you have.

So I think you're right. I think you need to be explicit with the public, not only in the room but also with the public about the balancing decisions you're making. And we tried to do that at the daily press conferences, where we talked about the economic harm of what we were doing.

And we knew we were doing economic harm with the public health interventions, of course we did. It was quite hard to count the economic harm, the public health harm was easier to measure. But even then, that public health harm changed because at the beginning, you'll recall, the consensus scientific view was you can't vaccinate against coronavirus. That will never happen. You won't get a vaccine. You'll be lucky in 20 years if you have a vaccine for this. Turns out it took 18 months.

So that is a game-changer for both the advice for how you do it, and would you have made different decisions on day zero if you knew a vaccine was coming on day 400? Maybe. But at the time of day zero, you didn't know the vaccine was coming on day 400. So inside that, I think honesty and exposing as much of the, let's call it your workings, as possible helps take the public with you.

You have to avoid mischief-makers. So, you have to avoid politicians who are trying to derail the powerful politicians at the time. I think we did that mostly in COVID. You have to avoid mischief-makers in the media who just want an alternative version of the truth.

And as we've already discussed, the disinformation and misinformation can become a challenge in that space because you almost become so honest that you leave yourself open to being buffeted by the daily waves of change.

### **Martin**

So you've described the range of inputs in terms of evidence and the advice that you were getting. And I know that talking to my colleagues in Scotland, people like Steve Reicher and others, it seems to have worked really well there.

You do seem to have been able to draw on all of these differing perspectives, and I'm not sure that that was necessarily the same everywhere else. But obviously, we shouldn't be commenting on that here. But do you feel that you did have access to all of the disciplines that you needed?

### **Jason**

I think so. When the history is written, I think Steve Reicher and Steve Reicher's team will have been crucial to Scotland and partly crucial to the UK.

Steve is one of Scotland's most prominent behavioural scientists. He was on TV quite a lot, actually, explaining public mood and public behaviour based on how you communicate with them. And his fundamental premise – this is terrible, Steve would hate this being summarised in such a way – but his fundamental premise is if you explain the 'why' people will do the 'what'. That's his lesson to me, to simplify it hugely.

Now, he could also tell you a lot more nuance about age groups, about demographics, about who was who, and nationalities, and how different communities react and behave and what they do depending on what you say. But fundamentally, I believed him when I had to get across the 'why' we were advising something, compared to, then, what we were requiring the public to do.

So, the Ranger v Celtic game being off is not how you should start the conversation in Scotland. You should start with, 'Look, we're trying to save this number of lives in older people who are in our care homes, who are in our societies. And in order to do that, unfortunately, we are required to postpone the Rangers v Celtic game.' And that's a different sentence from, 'You know what everybody? Rangers v Celtic is off. We're not telling you why.'

So, the behavioural scientists became really important in the conversations, and we had them on our big advisory groups. They fed into the conversations I had. The first minister met with Steve a number of times, and that was about trust.

We polled the population in Scotland every Friday, so we had really good data about what the population were both believing and doing, so were they trusting the message? But more than that, were they following the message? And we used that as part of the input to then the following week, or the weekends, adjusting the messaging to try and get the public to do what we knew needed to be done.

### **Martin**

And those data on trust are actually very impressive because you were able to maintain that high level of trust, at a time when it fell off a cliff in England, after a certain individual took a trip to Durham. But again, we shouldn't go into that in any detail.

One of the initiatives that you took, which I was really interested in, focused on four harms – the harms to health, health and social care, social harmony and economic harm. We've talked about this already a little bit, but this really seemed to work quite well.

Now, if I can go back to Anthony Seldon's book, it's in marked contrast to the situation in England. I don't expect you to comment on this, but there the cabinet secretary Mark Sedwill created a structure with five functions. And Seldon notes in the book, he says, 'It was a logical and coherent plan, or so it seemed.' But then he continues, 'In practice, it dissolved near instantaneously in contact with reality.' So, what do you think it was that explained your apparent success?

### **Jason**

I think we had senior civil servants and politicians who lent coherence. So, there is an invisible army of heroes. And I use those words deliberately, and they are senior civil servants. You'll have met them in your life, Martin. And they are geniuses. You've never heard or seen them on TV, but they are brilliant at bringing coherence to complexity.

And we have a number of them in Scotland. And they would come together around what you and I would put up on a PowerPoint slide and call a framework. They would make that framework real because we had a Four Harms Advisory Group. Sometimes it met every day; sometimes it met every week.

And the Four Harms Advisory Group was principally public health advice, advice for the health and social care harms being caused by the public health response. So, adding to waiting times, mental health, all of those things. Social harm – loneliness, education. And economic harm – GDP, business loss, unemployment.

That Four Harms group was then very quickly able to give a much more rounded... not exact, it wasn't able to say, 'Here's the magic advice, here's what you've been waiting for. This is exactly what you should do.' So, round that they were able to say, 'Here are the balanced judgments that you have to make. And here's what we think we should do in order to do that.'

Now, sometimes there were choices in there, of course, because if you have furlough, you can make a different choice, because you've got 80% of salaries being paid. If you don't have furlough, then you've got a different set of choices because your economic harm now becomes much more prominent because you can't pay people's wages.

So in there, there's some politics, which we were able to stay out of. We were just able to tell the truth about what the politics was doing. And then the first minister in Scotland was able to make judgments about how she would tackle those politics, conversations that we weren't in, and then how she was going to broadcast that to the media and stakeholders.

### **Martin**

So, it seems like this ability to structure a problem, so you don't have a situation in which one party is looking at the economic issues and the other party to the conversation is looking at the health issues and they're talking by each other. The fact that you can sort of set the parameters for a particular discussion really seems to be pretty important.

### **Jason**

It does. And I think we had the advantage, and I don't know if you agree, but I think we had an advantage of a single mission. One of the challenges with normal life is that we don't have a single mission. Now, if you're all pointing in the same direction and all saying like, 'The most important thing here is to get through this global pandemic that is killing what we now think is probably 20 million across the world.'

We have the economists, the social policy advisers, the public health. We're all in the same game. And frankly, the opposition politicians, the in-government politicians and the media, we're all in the same game, too. So, we had a single mission that we were all trying to do.

Now, it's a little bit more complex than that. Recovery of each element of the social cohesion is harder, because we've got waiting times, criminal justice has got waiting times, education is catching up. So, all of that is now in a big mishmash and we're not all focused on exactly the same thing. I think that becomes hard.

### **Martin**

So, I really like the emphasis that you have placed throughout this on frontline engagement. I often quote the English politician Douglas Jay in 1937, when he said in the gendered language of the time, 'The gentleman in Whitehall really does know best.'

And of course, we have seen so many times when policies have been made without engaging. The book *The Blunders of Our Governments* is full of them, and in fact, the authors of that conclude that was the unifying factor between many of the blunders they described. But do you think that we do manage to get enough frontline engagement when we're developing policy?

### **Jason**

No, of course not. I don't think you can probably ever have enough. We've started to do some work with what I would collectively call designers. And they are much, much better at this than us. They don't talk about co-production, they don't talk about temporarily walking in other shoes like I have. They co-design.

I mean, they go to the work, and they were about to do it around our National Care Service in Scotland, which is probably the biggest reform in 75 years in the national health and care systems of Scotland. And we are trying as far as possible to co-design that with those with lived experience, those who care or are cared for, and everybody who works in those establishments.

So, I don't think we're as good at that. I think we're much better at listening than we've been. We have a thing in Scotland called Care Opinion, which is across the whole country. They have it in bits of England. They don't like this summary, but it's the quickest way of describing it – it's TripAdvisor for health and care.

So, you're able to give real-time feedback about your experience. 70% of the stories – and we have 80,000 stories on that now from Scotland – 70% of them are 100% positive. So you get, of course, the complaints and the other side, which is really important, but you also get a lot of positivity, which is lost usually in feedback systems and complaints.

So, I think we do hear more from those we serve, but we can of course get better. And I think of the design of how Scotland or the UK designs the future health system. And we're always designing the future health system. We think it's a single point in time – it's not, it's a continuous process. Then the more we can hear from those we serve, the better the result will be.

### **Martin**

Now we've talked a bit about the trust of the public in politicians, but it's also the case that there is a need for trust between a health adviser like yourself and the politicians they advise

in a crisis. But I can see that this must be complicated. And if you can take maybe one example, you were criticised when you defended Nicola Sturgeon when she was seen, albeit only momentarily, to step inside a shop and had forgotten to put on her mask.

So, would you have any advice for others who find themselves in your position about how to develop and maintain these trusted relationships with the politicians you're advising, and are there any traps that they should try to avoid?

### **Jason**

Yeah, it's an interesting question. I was, right early on – I'm a fairly extrovert, friendly chap – and right at the beginning of my, let's call it my government career, although that's an exaggeration for sure. It was with a senior health secretary and I was in the room and chat, chat, chat, made a cup of tea. Can't even remember what the policy conversation was about.

And when I came out, the senior civil servant who was a little bit of a grey man, frankly, took me aside and said, 'These people are not your friends, you know that.' I said, 'What do you mean? They're lovely.' He said, 'They're not your friends. You can absolutely be friendly, but they're not your friends. It's a different thing.'

In the civil service, the UK civil service, and it's true in a lot of countries. I've spent time in Scandinavia, there's a very similar relationship. There is a boundary or a wall between decision maker and adviser. And it's there for good reason, because you can get lost in that kind of, let's call it power with a small 'p', inside that world of special advisers and politicians and the drive for whatever it is they're doing.

So, you do have to be cautious. That doesn't mean, I don't think, that you can't go in and say, 'Would you like a cup of tea, minister, because I'm having one?' Or the minister can't make you a cup of tea. I think you can take it too far in either direction.

And COVID forced us to spend every day together. I mean, we were with the politicians every day, for quite long periods of time. So you, of course, become more friendly than you would have before because you're going to buy a lunch and you buy everybody lunch or whatever. You're human. But you do have to realise that democratically elected politicians and senior civil servants have different roles within that puzzle.

That's true in local government. It's true in community-based government, and it's true in national government. So, you have to be careful, but you have to also spend time in that puzzle in order to gain trust, because the deputy first minister is going to need senior advisers sitting alongside him then, her now, because we've got a new one, inside parliamentary committees. And they want to know that they can trust you to tell the truth, to not over-speak.

So, I think there's a balance in there of friendship and professionalism that is quite hard to strike. But we're human and good people can work out.

### **Martin**

Now, I want to ask a couple of practical questions and some we've touched on a little bit already. But one of the issues is that it really is important to get the facts right whenever

you're presenting public health issues and briefings to the public. Now, I'm not going to mention names here, but some of us may recall a cabinet minister from south of the border and the cabinet minister said, and I quote, '300,034 974,000 tests were carried out.' You know, a nonsense number.

When you're in the glare of the cameras, it's easy to mis-speak, though arguably, that minister should have corrected themselves. How do you avoid situations like this, and particularly when you're presenting complex information, particularly numerical information – do you use notes? Do you use autocues, teleprompters, or do you rely on your memory?

### **Jason**

I try and rely on my memory, particularly for TV. For radio, you can have some stuff written down in front of you, but increasingly radio now want to film you because they tend to use the one interview for all elements of the broadcast media, so online radio and TV. And newspapers, you can have notes a little bit.

When we did the live press conferences, I would have notes in front of me about what I thought was going to come up. So, it might have been a vaccine rollout day, or we might have been publishing mortality data that day, and I would try and have something catchy that would get over the messaging we were trying to get across.

So, let's say we were on a vaccine day. And I would want to be able to say, 'Look, we've done 34% of the under-14s. This is fantastic in two days, but we need to go for 60 by the end of the week.' Or something like that. So, numbers are really useful. And I tended to have three numbers that I always had in my head, and I would use those three numbers throughout the day.

And then the next day, the three numbers would change. It would depend on what the story was; if it was elite sport, or if it was faith and belief, or if it was vaccination. So, my own personal version was I would try and have three 'catchy' in inverted commas – that's in the eye of the beholder, of course – statistics that would allow me to get across the message I was trying to do.

The other thing I would try and do, and this was a little bit trickier in COVID, but I'd try and do it in my normal communication life, is I would try and have narrative and story that would help get my message across. Now, in my normal world, that's usually from visits.

So, I could tell you that last week I went to an intensive care unit. I met an intensive care nurse who told me that she saw five deaths in four hours. That's horrific for anybody. That's post-traumatic stress. She's going to struggle to recover. Her staff are going to struggle to recover. And we worked out that of those five deaths, those people had met 200 members of staff in the few days before they died.

So, you now take it from the patient to the family, to the wellbeing of the workforce and you've got a story on which you can build a series of messages – principally, of course, about the tragedy of COVID and the family and the horror of the grief that the family have. But you

can also make that about the wellbeing of the staff, from the mortuary attendant to the porter to the ICU nurse and everybody in between.

So, I tried to have stats if they were available, and I would often have public health experts in the background feeding me that kind of statistic because they knew that's how I worked. But I was also trying all the time to have a story, something funny or something serious that would allow me to get that same message across.

### **Martin**

And that's a message that's come across again and again in this series, the importance of narrative. So, one of the other interviews was with Ian Purcell, who's a professor of primary care, who's been doing a lot of work with the COP, the climate change conferences, and has been describing how they've used narrative theatre stories in a very imaginative way.

I'm reminded, listening to your comments about the public presentation, I have recently read a book called *Punch and Judy Politics*, which is about the preparation for Prime Minister's Questions and looking at the way in which different prime ministers have done that and have approached it with the need to get data on such a wide range of issues.

Second practical question, I've been going through lots of press cuttings and preparing for these podcasts, and it seemed to me that on a number of occasions you had fallen victim to your words being taken out of context to create a story.

And I'm thinking of some of the examples of musical concerts. I've learned a great deal about your musical tastes, by the way, as well, about concerts by Deacon Blue and Stereophonics, for example. So how do you deal with that, when stories are made that really are taking things quite out of context? Do you take the view that today's papers are tomorrow's fish and chips wrapping, or do you try to correct the record?

### **Jason**

It's slightly more complex. You have three options. The most likely option is ignore it, and that's usually the comms advice. So usually if you're partially quoted, which is usually what's happened, you're rarely completely misquoted, but you're often partially quoted. So, therefore, the story looks a little different from what you intended.

The usual communication advice from the professionals is ignore it. If two other papers take it up, then we might do something with it. But the reality is it will probably die tomorrow. And actually, if you complain, the story tomorrow will be, 'National clinical director complains about our story yesterday and here's what we said yesterday.' So, all you've done is repeat it again.

The second thing is embrace it. Embrace it and make it funny. So if you have the opportunity to go back in the media... So, when I cancelled Christmas and I was suddenly the Grinch in all the newspapers, we were able to talk about Christmas. The first minister actually looked at me and called me the Grinch at the next day's press conference. So, we use it as a mechanism by which we can then communicate what we actually want to happen at Christmas.

So, the second option is just don't worry about it too much. Just run towards and embrace it. So recently it was suggested I thought schools shouldn't have closed in the pandemic. That's not true. I didn't say that. So, the next day I was able to say, 'Let's talk about schools again, can we? Because I'd just like to say what... etc.'

And then the third option, and this is not used often, is if you truly believe that you have been misquoted or the story is incorrect and worthy of correction, then you should do that. And we've done that. We do it very rarely because it's usually not worth the effort and the cost of doing it.

But you also should draw lines. I mean, if they attack me on a personal level, my integrity, my family, that's when I begin to get a little bit more likely to do that. If it's a selective quote, for the purposes of the political agenda of that particular media outlet, then frankly, you probably should let it go and just hope that it disappears the following day.

### **Martin**

Yeah. And also, we know from the research evidence that an authoritative correction can actually reinforce the incorrect view that came out first.

So, we're almost at the end, and I've got two final questions that I ask everyone, personal questions. Now we're talking in this series about inspiring doctors, in your case, dentists, as role models. And I'm wondering who are the people that have inspired you or are still inspiring you and why?

### **Jason**

So, my father is, of course, the first person in that question. He was a coal miner from Fife, went down a pit at 14 years old with no qualifications. And then the very quick summary is that he became an electrician, became an electrician in the pit and then in the real world, and did an Open University degree at the same time as I was at university.

So, we studied at the dining room table at the same time. He retired as the head of engineering and shipbuilding of a further education college. So you can't have my life without being inspired by him and my mother's support of him and I and everybody else.

On a professional level, I've had a series of clinical mentors. The surgeon who taught me to operate. More importantly, the surgeon who taught me not to operate, which is a different skill and a really important skill. And then a series of public health people.

And I think probably Don Berwick. So, Don Berwick was the founder and chief executive of the Institute for Healthcare Improvement in America, when I had the privilege of going when I went to Harvard to do public health, and he and I have stayed in touch. I was with him this week in Copenhagen at the European Quality Forum, and he's been a very important figure in my professional life in the last 15 years.

And I would argue one of the best communicators, both with clinicians and the public, that we've ever had in our professions. He's got a different style, perhaps from you or from me. He gives speeches – they're written, you can buy them, and they're published often in anthologies

of his speeches – but they are just terrific. He does the narrative story better than anybody else, I think, in our field. So, he's been a terrific communication and clinical mentor.

**Martin**

And the very last question, what advice would you give to someone, perhaps someone inspired by listening to this podcast who's just graduated in medicine or dentistry and would like to follow in your footsteps?

**Jason**

Well, I'm not sure they can because it's completely imagined and made up. But if we want to do clinical public health, political communications, I think the first thing to do is get yourself a specialty. It doesn't have to be a true specialty. It can be general practice in dentistry or medicine, of course it can. They are specialisms. So, make sure you do your apprenticeship. So become a clinician, is my first piece of advice to relatively young people.

That doesn't mean you have to do that without any look at research or education. Of course you should be broad, and you should do those things. Don't worry about making a life choice in your 20s that's going to stay with you to your 60s, because that's not what happens anymore. You're choosing for the next little phase of your career. You're not choosing for life, but choose an area and become a clinician.

And then over time, spend time in all of the different elements that this offers to you. It might be publishing, it might be communication, it might be education, it might be research, and you'll find the thing that drives you. You'll find the thing that gets you up in the morning and gets you excited. And then that's what you should then balance your clinical career with.

And that's what most people do. They end up as clinical managers, clinical educators, clinical researchers. Increasingly in my world, clinical improvers. So that intensive care nurse who I was talking about a moment ago, she is a clinician pretty much full-time but is known in her piece of the puzzle as the improver. So, she has the quality improvement skills in order to make it better.

So that's what I would do. And that might be communications, it might be policy, or it might be inside your clinical environment in a hospital that you stay in for decades, but you become the improver, or the educator or the researcher inside that establishment.

**Martin**

Well, that sounds like very good advice indeed. At least it's very similar to the advice that I tend to give people as well. So, I'm delighted to hear it. Jason Leitch, thank you very much indeed.

**Jason**

Thank you for having me.